Affordable Care Act (ACA) Maternal, Infant, and Early Childhood Home Visiting Program
HRSA Award #6X02MC19410-01-01
Montana Needs Assessment

OVERVIEW OF MONTANA[i]

Demographics: Montana ranks fourth among all the states in terms of land area, encompassing 145,552 square miles, 56 counties, and seven Native American reservations. Montana is 44th in terms of population and is one of only a few states with a population under one million; however, between 2015 and 2020 the population is projected to reach one million. Between 2000 and 2008, Montana's population increased from 902,190 to 967,440—a 7.2% increase and the population density increased from 6.2 to 6.6 people per square mile. Montana has approximately 12,500 births per year and a crude birth rate of 13.0 per 1,000 population. The number of births has increased 17% over the past decade. The crude birth rate and general fertility rate (births per 1000 women 15 to 44 years) have also increased.

Over the last decade, the in-state population has been redistributing to the western portion of the state and into urban areas. The 2008 census estimate shows that Montana has six counties with a population over 50,000 people and that 59% of Montanans reside in these six counties. The remainder of the population is dispersed into smaller communities, farms, and ranches.[ii]

Montana's largest county has fewer people than many small to medium sized cities in other states. Yellowstone County, the most populous county, has approximately 150,000 people, while the smallest county in the state has fewer than 500 residents. Montana has three metropolitan areas (core urban areas of 50,000 people or more) and five micropolitan areas (urban cores of 10,000-49,999 people), all but one of which are in the western half of the state.

Billings is the largest city in Montana and is located in Yellowstone County, in the south central portion of the state. Bozeman and Kalispell, located in Gallatin and Flathead counties, respectively, are the fastest growing cities in Montana; both with a population increase of over 40% between 2000 and 2008. (See the map in Appendix 1)

Over 90% of Montana's population is white, with the largest minority being American Indians. According to the 2008 census estimate, there are 62,399 self-identified American Indian/Alaska Native, or about 6.4% of Montana's total population. Approximately 37,871 American Indians, or about 57.4%, live on one of the state's seven reservations. The Blackfeet and the Flathead reservations are the largest, with 8,665 and 7,853 American Indian residents, respectively. Rocky Boy's (2,598) and the Fort Belknap (2,805) reservations were the smallest.[iii] Age and race demographics are described in Table 1.[iv]

2009 Estimates of Montana and U.S. Population by Age and Race		
2009 Estimates	**Montana**	**US**
Population	974,989	307,006,550
Percent Change 2000-2009	8.1	9.1
Persons under 5 years (%)	6.4	6.9
Persons under 18 years (%)	22.5	24.3
Persons 65 years and over (%)	14.6	12.9
Female persons (%)	50.0	50.7
White persons (%)	90.3	79.6
Black (%)	0.7	12.9
American Indian and Alaska Native (%)	6.4	1.0
Asian (%)	0.7	4.6
Native Hawaiian and Pacific Islander (%)	0.1	0.2
Two or More Races (%)	1.8	1.7

Table 1

Education: Montana continues to have a high rate of high school completion, approximately 82% in 2008-2009. The completion rate is lower for American Indian students than for white students.[v] The percent of Montana's population 25 years of age and over with a

bachelor's degree or higher is similar to the US rate: 27.1% and 27.4%, respectively, in 2006-2008.[vi]

Economics: Montana's per capita income is lower than that of many US states. In 2008 Montana had a per capita personal income (PCPI) of $34,622, which was 86% of the national average of $40,166. [vii] Low salaries and seasonal work in Montana increases the likelihood that workers will hold multiple jobs; with more than 30% of workers who earn between $5,000 and $15,000 working more than one job.[viii] The number of women in Montana who hold more than one job has almost doubled since 1970, with women being more likely than men to have at least two jobs. [ix] Montana has the nation's largest gender-wage gap in the US, with women earning only 67 cents for every dollar earned by their male counterparts[x].

In July 2010, Montana's unemployment rate was 7.3% lower than the national rate of 9.5%, but higher than most other states in the region, such as North Dakota (3.6%), South Dakota (4.4%), and Wyoming (6.7%).[xi] Despite Montana's low (compared to the national numbers) employment rate, many of the jobs in the state are low or minimum wage, meaning that much of Montana's population lives in poverty. In 2008, approximately 21% of Montana's children under age 18 years were living in poverty, compared to 18% in the US as a whole.[xii]

BACKGROUND OF HOME VISITING IN MONTANA

Montana has a long history of home visiting maternal and child health populations. Frontier nurses provided home visits to women in mining and agricultural communities in the late 1800s and early 1900s. Early accounts described services that included prenatal and infant care as well as counseling and support, recognizing that many families left behind their support systems when they traveled to the frontier. Throughout the 1900s, home visiting services to Montana's maternal and child health (MCH) populations have been provided by a variety of

agencies and individuals, including public health nurses, social workers, nutritionists, and paraprofessionals. As in other states, home visiting programs in Montana have targeted a variety of issues, including health promotion, child abuse prevention, and environmental assessment, and have grown and ebbed with the availability of human and fiscal resources.

Montana views the Affordable Care Act (ACA) Maternal, Infant and Early Childhood Home Visiting program as an opportunity to focus, clarify, and expand maternal and child home visiting services in the state. Deanne Gomby and others describe home visiting services which have been designed to address:

- poor birth outcomes (low birth weight and premature births, maternal and infant morbidity, and infant mortality),
- child intellectual and social development,
- early and continuous use of preventive health services by the family,
- child abuse and neglect, and
- life course of mothers and families, including promoting education and employment, decreasing the incidence of subsequent pregnancies and decreasing the use of public services including food stamps and welfare. [xiii] [xiv]

Nationally, home visiting programs today continue to focus on many of the issues identified above, while some have been designed or restructured to focus on providing family and parent support, promoting parenting competence, assisting families to be economically self-sufficient, improving school readiness, promoting safe and educationally supportive home environments, decreasing environmental risks, increasing breastfeeding, decreasing parental substance and tobacco use, decreasing maternal depression, and decreasing costs associated with medical services. [xv] [xvi] [xvii] [xviii] [xix] [xx] [xxi]

The proposed purpose of the ACA Home Visiting funding, as described in the legislation, is the development and evaluation of home visiting program(s) that address:

- Improved maternal and newborn health,
- Prevention of child injuries, child abuse, neglect, or maltreatment, and reduction of emergency department visits,
- Improvement in school readiness and achievement,
- Reduction in crime or domestic violence,
- Improvements in family economic self-sufficiency, and
- Improvement in the coordination and referrals for other community resources and supports.

Furthermore, the legislation allows for the state to select and subsequently demonstrate improvement in at least four of these areas after a period of three years.

MONTANA'S DEFINITION OF HOME VISITING

For the purposes of this project, home visiting will be defined according to the Supplemental Information Request (SIR), which described early childhood home visiting programs to be: "Programs or initiatives in which home visiting is a primary service delivery strategy and in which services are offered on a voluntary basis to pregnant women, expectant fathers, and parents and caregivers of children birth to kindergarten entry."[xxii] Experts in the home visiting field agree that home visiting is essentially a "strategy for service delivery" rather than a specific, uniformly defined service, allowing visitors to assist families to address social, environmental and economic issues negatively affecting their health. [xxiii] [xxiv] [xxv]

Montana's ACA Home Visiting program will support community based efforts to promote healthy life course development for families in at-risk communities, with a primary

focus on improving the health of the MCH population by strengthening and improving the programs and activities carried out under Title V. Life course concepts recognize social, economic, and environmental factors as underlying contributors to poor health and development outcomes for children, as well as to persistent inequalities in the health and well-being of children and families. Based on a socio-ecological theoretical framework, home visiting delivers services recognizing that children develop within families, families exist within a community, and the community is surrounded by the larger society. These systems interact with and influence each other to either decrease or increase risk factors or protective factors that affect a range of health and social outcomes.

MONTANA'S DEFINITION OF COMMUNITY

Pregnant women, parents and caregivers, and children from birth to 8 years of age and their families, were identified in the initial Funding Opportunity Announcement (FOA) as the populations of interest for the state's ACA Home Visiting Program. The FOA also required states to assess the demographic, economic, and social service data of the population and in so doing define what is meant by community. The most detailed level of data available are often county-level data.

In Montana, communities are frequently described in terms of county structure. For the purposes of this ACA Home Visiting Program Needs Assessment, community is defined as a county. Much of the analysis uses county data and also considers the "concentrations" of populations within the county. For instance, although some of the counties with larger populations may have lower rates of low birth weight infants than less populated counties, the larger counties have a higher number of low birth weight infants because of the population size.

Public health and social service systems are typically organized as county structures, with county commissioners and County Boards of Health having legal and contractual responsibility for service delivery and public welfare within the county as a whole. Tribal nations have separate health and social service structures serving the seven tribal reservations. Tribal land boundaries are superimposed over county lines, yet vital statistics and data tied to state and federal systems are reported as county, not tribal data.

AT-RISK COMMUNITIES

Current Definition of at risk population for the PHHV Program

In SFY 2010, Montana had contracts with 14 county health departments to provide home visiting programs for high-risk pregnant women and infants. Public health home visiting services for pregnant women and young children began in Montana in the late 1980s with pilot programs in four communities. These pilot programs were consistent with national trends to create programs that encouraged early entry into prenatal care with an end goal of improved pregnancy outcomes.

Funding from the Montana Department of Health and Environmental Services, now the Department of Public Health and Human Services (DPHHS), was used to hire part-time public health nurses to identify women who needed help finding and paying for prenatal services and to visit and assist these women with access to prenatal care. Public health nurses, in the four communities, visited women in the women's homes. This service, initially intended to be a single home visit to assess needs, instead became a variety of services provided through a series of visits. Originally intended as a program in which nurses referred women to physicians, the nurses quickly found themselves receiving referrals from primary care providers who requested assistance for their clients who needed transportation, housing, insurance, and other community

services.

Based primarily on anecdotal reports from clients and providers regarding their satisfaction with the services, legislation was introduced in 1989 to formalize and expand the program. Montana's Initiative for the Abatement of Mortality in Infants (MIAMI) was envisioned to "…ensure that mothers and children, particularly those with low income or limited availabilities for health services receive access to quality maternal and child health care services."[xxvi] The bill was presented as a mechanism to improve pregnancy outcomes and decrease infant mortality, and as a potential cost savings measure. Proponents claimed that the high cost of neonatal intensive care could potentially be resolved, in part, through the provision of comprehensive, coordinated services to high risk pregnant women.

MIAMI was approved by the 1989 Montana legislature, with stated purposes of (1) ensuring that mothers and children receive access to quality maternal health services, (2) reducing infant mortality and the number of low birth weight babies (5½ pounds or less), and (3) preventing the incidence of children born with chronic illnesses, birth defects, or severe disabilities as a result of inadequate prenatal care[xxvii]. A series of strategies to address this legislation, including the expansion of the four pilot programs that offered home visiting services, were implemented and remain today.

Montana's home visiting program originally targeted and continues to focus on "high risk" pregnant women and their infants. The original MIAMI program model identified risk factors as "moderating factors," identifying conditions that were perceived as potentially having negative effects on pregnancy outcomes. These conditions included demographics, pre-pregnancy health status, obstetric history, and socioeconomic factors. Early program planning was based on the home visitation work by David Olds; however, unlike the Olds model, and due

in great part to Montana's sparse population and limited public health resources, the program was open to all at-risk women, regardless of maternal age or parity. A woman was considered "at risk" if she:

- was age 17 years or younger;
- had medical factors that indicated the potential for a poor pregnancy outcome;
- used alcohol or illicit drugs or had someone in their immediate environment who used alcohol or drugs;
- was in an abusive relationship; or
- was homeless.

Medical risk factors were outlined in MIAMI Home Visiting Manuals. They included a history of preterm labor or delivery, history of chronic health conditions such as hypertension or diabetes, and/or pregnancy induced conditions including pre-ecclampsia or gestational diabetes.

If a woman did not qualify for services under these criteria, she could also be qualified if she demonstrated an "inability to obtain necessary resources and services" and met at least three of the following criteria:

- a history of physical or sexual abuse;
- no support system or no involvement of a spouse or other supporting person;
- one or more children under age five;
- not educated beyond the 12th grade level;
- a physical disability or mental impairment;
- no prenatal care before or during the first 20 weeks of gestation;
- a refugee;
- age 18 or 19 years; or

- limited English proficiency [xxviii].

Demographics of clients varied from contractor to contractor, with some programs serving only very young mothers, others serving high (or low) ratios of American Indians to white populations, and some serving almost exclusively Medicaid clients. In 2003, due in part to legislative scrutiny, an assessment of the data received from contractors revealed much variation in the delivery of home visiting services, the frequency of visits, and the per client costs. In order to standardize services and funding distribution, a Request for Proposals (RFP) for Public Health Home Visiting (PHHV) services was issued in 2004. The RFP established the home visiting team structure, the minimum standards for the number of women and infants to be served, the number of visits required during the prenatal and infant periods, and required the communities to describe the method of case finding and community outreach they would use.

Sixteen proposals were received from communities, and fourteen contracts with county health departments were established in 2004. Since then, additional outreach and procurement activities resulted in the addition of two tribal program sites, however, due to staffing challenges, one of the tribal programs stopped providing services effective June 2010.

Interpretation of Prevalence of Risk Factor Data: The ACA Home Visiting SIR Guidance directs states to examine risk based on factors such as the ones described above. As noted, not all data are available at the county level in Montana, but county level data were obtained for the factors as described in the supplemental information request, and three additional factors related to maternal and child health are also included. For the four substance abuse factors noted in the SIR guidance, data are reported on whether the county is located within a region with high rates of substance abuse.

The risk factor data include:

1. Percent of live births that were premature/preterm (before 37 weeks), 2004-2008
2. Percent of births that were low birth weight (<2,500grams), 2004-2008
3. Infant mortality rate (per 1,000), 2004-2008
4. Under age 18 in poverty, 2008
5. Crime rate, 2009 (rate of the seven index crimes per 100,000 people)
6. School drop out rate, 2007-2008 school year
7. Within a region of the state with high binge alcohol use, in the past month, 2007-2008
8. Within a region of the state with high Marijuana use, in the past month, 2007-2008
9. Within a region of the state with high nonmedical use of prescription drugs, in the past month, 2007-2008
10. Within a region of the state with high use of illicit drugs, excluding Marijuana, in the past month
11. Unemployment rate, 2010
12. Child maltreatment/abuse (substantiated) rate, 2010
13. Domestic violence rate, 2009 (rate of reported domestic violence per 10,000 women aged 15-44)

(Additional Measures)

14. High school student binge alcohol use, 2008
15. High school student cigarette use, 2008
16. Smoking during pregnancy, 2005-2007

Associations between contextual and individual determinants of health have been well documented, and effective health policy development depends upon sound analysis of factors impacting health. [xxix] [xxx] [xxxi] The ACA Home Visiting Needs Assessment guidance provided a number of factors frequently used as MCH indicators, including measures of infant health as well as socioeconomic factors. As noted elsewhere in this document, for the purposes of the ACA Home Visiting Needs Assessment, communities in Montana will be described and defined as counties.

The FCHB staff worked with numerous organizations and agencies to obtain appropriate data, the majority of which are county-level. Data sources are summarized in Table 2.

ACA Home Visiting Needs Assessment Data Sources		
Required Data Measures		
Indicator	**Source**	**Data Source**
Premature/preterm Births	2008 Birth and Death Certificates - Vital Statistics	Montana Department of Public Health and Human Services (DPHHS)
Low Birth Weight Births		
Infant Mortality		
Poverty	Small Area Income and Poverty Estimates - 2008	US Census Bureau
Crime	Data Base of Crimes Reported to Law Enforcement - 2009	Montana Board of Crime Control
Domestic Violence		
High School Dropouts	Kids Count Data Center – 2007/08	Annie E Casey Foundation
Substance Abuse	National Surveys on Drug Use and Health—2006-2008	Substance Abuse and Mental Health Services Administration, Office of Applied Studies
Unemployment	July 2010 County Labor Force Statistics Non-Seasonally Adjusted (Preliminary)	Research & Analysis Bureau, Montana Department of Labor and Industry
Child Maltreatment	SFY 2010 CFSD Child Abuse Reports	Child Family Services Division, DPHHS

Additional Data Measures		
Indicator	**Source**	**Data Source**
Teen Tobacco Use	Prevention Needs Assessment (2008) and National Survey on Drug Use and Health (NASDUH)	Addictive & Mental Disorders Division, DPHHS and DHHS Substance Abuse and Mental Health Services Administration
Teen Alcohol Use		
Smoking During Pregnancy	2008 Birth and Death Certificates-Vital Statistics	Montana Department of Public Health and Human Services (DPHHS)

Table 2

Data discussed in the following section is summarized in Appendix A.

Maternal Child Health Indicators: Infant deaths (mortality) occurring prior to a child's first birthday is a typical measure of both pregnancy outcome and societal health. Premature birth (defined as those occurring before 37 weeks of gestation) and low birth weight births (<2500 grams) are strongly associated with infant mortality. [xxxii] [xxxiii] Montana's low birth weight rate in 2007 was 7.2%, compared to a US rate of 8.2%. The prematurity rate that same year was 11.9% in Montana, compared to 12.7% in the US. [xxxiv] Twelve of Montana's 56 counties did not have prematurity or low birth weight rates reported during the 2004-2008 time period due to a small number of births. Rates of reported county level prematurity rates ranged from 4.3% to 12.1%, and low birth weight rates from 4.2% to 15.2%. Montana's infant mortality rate for the time period 2004-2008 was 6.1 deaths per 1,000 live births, compared to a national rate of 6.75. [xxxv] [xxxvi] Infant mortality rates for the same time period in Montana counties ranged from 2.0 to 28.8 deaths per 1,000 live births, with no rates reported for 14 counties.

Socioeconomic Indicators: Data indicating socioeconomic indicators includes reported poverty rates, unemployment and school dropout rates. Poverty and unemployment rates are monitored and reported by the Montana Department of Labor and Industry and the Office of Public Instruction. Montana's Department of Education monitors and reports on school dropout

rates. For the purposes of this ACA Home Visiting Needs Assessment, poverty rates for children under age 18 are of particular interest. Rates for 2008 were reported for all counties, ranging from 10.8% to 33.8%, compared to a state average of 19.2% and a national rate of 18%.[xxxvii] Unemployment rates for July 2010 were also available for all counties, ranging from 2.6% to 14.8%, compared to a state average of 6.8%. School drop-out rates for the 2007-08 school year ranged from zero to 11.6% compared with a state average of 5.0% and a national average of 6%.[xxxviii] One additional indicator, indicating both income and health service utilization, is the percent of resident births paid for by Medicaid. Approximately 31.2% of Montana births were paid for by Medicaid in 2008 and 2009, with a range for the counties of 5.7% to 57.7%.[xxxix]

Crime and Violence Indicators: Data indicating crime rates, domestic violence and child abuse are also available by county; however, crime data reporting is extremely variable, impacted by the availability of police officers and other enforcement personnel, and the availability of resources for those experiencing domestic violence by county. Five counties had no reported crime rate, 10 had no domestic violence reported, and 8 had no child abuse reported. Crime rates, indicating the rate of occurrence of the seven "index," or most serious crimes (homicide, rape, robbery, aggravated assault, burglary, larceny and motor vehicle) per 100,000 people ranged from 162 to 4,874, with a state average of 2,826 per 100,000 population. Domestic violence, which is calculated based on the reports of domestic violence per 10,000 women aged 15-44, ranged from 24 to 583, with a state average of 229 reports per 10,000 women 15-44 years of age. The child abuse rate reflects the rate of substantiated child abuse reports, meaning the allegation of maltreatment or risk of maltreatment was investigated and supported. The child abuse rates ranged from a low of 5 to a high of 247 cases per 10,000 children under age 18, compared to a state rate of 38 per 10,000 cases per 10,000 children. [xl]

Substance Use Indicators: According to the National Survey on Drug Use and Health (NSDUH), Montana routinely ranks among the worst 20% of states for tobacco, alcohol binging and illicit drug use.[xli] Table 3 summarizes Montana and US substance use data for 2007 and 2008.

NSDUH Substance Use Data for Montana and US (2007 and 2008)				
Indicators	**Age Groups**	**Montana**	**US**	**NSDUH Source Table**
Prevalence rate of binge alcohol use (5 drinks) in last month	12-17 yo 18-25 yo 26+ yo	11.55 50.28 24.63	9.25 41.40 22.01	Table B 10
Prevalence rate of marijuana use in past month	12-17 yo 18-25 yo 26+ yo	8.60 22.87 5.79	6.67 16.45 4.06	Table B 3
Prevalence rate of nonmedical use of pain relievers in past month	12-17 yo 18-25 yo 26+ yo	7.65 14.87 3.67	6.56 12.05 3.44	Table B 8
Prevalence use of illicit drugs, excluding marijuana, in past month	12-17 yo 18-25 yo 26+ yo	4.88 9.27 2.86	4.53 7.96 2.71	Table B 6

Table 3

Sub-state level NSDUH data for Montana uses a regional grouping that divides the state into five areas. Because Montana has such a high prevalence of substance use, even though county-level data were not available for these substance abuse measures, a community's risk was considered high if they were within a region that reported high substance use.

To provide a county-level perspective on substance use among children, two additional measures on binge drinking and cigarette use among high school students were included. The Prevention Needs Assessment is a survey of high school students conducted by the Addictive and Mental Disorders Division at DPHHS every two years. The survey includes many of the same questions used on the NSDUH survey, and while school participation is voluntary, county reports based on weighted data are generated for districts with acceptable rates of school and

student participation. In 2008, there were no data reported for seven counties. In 2008, county rates ranged from 17% to 64% of students reporting they had ever used cigarettes, compared to 35.8% statewide. That same year, a low of 9.4% to a high of 45.7% students reported they had had five or more alcoholic drinks (binge drank) in the previous two weeks, compared to a state average of 23.5%[xlii].

Another additional measure on substance use is tobacco use during pregnancy. Montana has high rates of smoking during pregnancy, and this topic was identified as a priority area through the 2010 Maternal and Child Health Needs Assessment.

Definition of At Risk

A very simple method of establishing risk was developed by examining each measure for each county, and determining the measures for which the county had a higher prevalence than the state. For example, a county with an infant mortality rate (IMR) of 8.8 per deaths 1,000 live births would be considered at higher risk than the state as a whole, which had an overall IMR of 6.1 for the same time period. Each indicator was given a weight (described below) and every time the county had a "higher risk" than the state, the weight for that indicator was added to their score. Weights were assigned to account for multiple measures on one category. For instance, if each of the seven substance abuse measures counted separately, a community could be considered high risk even though they had no other risk factors, and based in a large part on regional data, instead of more useful county-specific data.

Since some counties were missing some data and could not possibly reach the same score as the counties with complete data, a percent of the total possible score was calculated for each individual county. The average score was 38% of all possible points for the indicators. Counties who scored higher than 38% of their total points were considered at risk based on the community

risk indicators. Based in the community risk indicators alone, 27 counties were identified as "at risk."

Community risk indicator	Weight	Reasoning
Premature/preterm Births	0.5	Related to low birth weight measure
Low Birth Weight Births	0.5	Related to premature/preterm measure
Infant Mortality	1	Distinct measure
Poverty	1	Distinct measure
Crime	1	Distinct measure
High School Dropouts	1	Distinct measure
Within region of high binge alcohol use	0.25	Regional data, not county-level; multiple other substance use measures
Within region of high Marijuana use	0.25	Regional data, not county-level; multiple other substance use measures
Within region of high nonmedical use of prescription drugs	0.25	Regional data, not county-level; multiple other substance use measures
Within region of high use of illicit drugs, excluding Marijuana	0.25	Regional data, not county-level; multiple other substance use measures
Unemployment	1	Distinct measure
Child Maltreatment	1	Distinct measure
Domestic Violence	1	Distinct measure
Teen Tobacco Use	0.5	Similar to teen binge alcohol use; multiple other substance use measures
Teen Alcohol Use	0.5	Similar to teen smoking; multiple other substance use measures
Smoking During Pregnancy		Priority identified during 2010 Montana MCH needs assessment process; relates to health of women, infants, and young children

Population Indicators

Because of the importance of considering populations and actual numbers of events when identifying concentrations of risk, communities are also identified as being at risk if they have at least one health or socioeconomic risk factor and "concentrations" of maternal and child populations. Thirty counties had no population concentrations, 13 had one, 9 had two, and four had three population concentrations.

While county level rates can indicate an elevated risk, they do not necessarily indicate a "concentration" of the outcome of interest. Counties with lower health or socioeconomic risks, may in fact have a higher concentration of populations at risk simply due to the number of people. For example, one community with an elevated rate of preterm birth has an average of 22 births – approximately 3 of which were preterm – annually. On the other hand, one of the micropolitan counties has a low overall rate of preterm birth, but over 1,000 births each year, an estimated 86 of which are preterm. Several metropolitan areas also have higher percentages of population that are potentially home visiting populations, specifically, women 15-44 and young children.

The population factors that were considered are:

1. Percent of population that is females 15-44 years of age
2. Percent of population that is children 0 through 5 years of age
3. Fertility rate (births divided by the number of women 15-44 in the county), per 1,000

The first two population factors were included because they correspond with target populations for most home visiting programs related to early childhood. Also, preconception health was identified as a priority during the 2010 maternal and child health needs assessment, and interventions for that topic area would focus on women 15-44 years of age. The fertility rate was included as an indication of the births in relation to the overall population. Finally, whether the county is considered a micropolitan or metropolitan area, according to the census definitions, was also considered. These counties have the highest populations in the state, and thus will have the greatest "concentrations" of risks just because of the number of people.

The population indicators were also weighted. The percent of the county population that is females 15-44, the percent of county population that is children 0 through 5, and the fertility rate were each assigned a weight of 0.5. Each of these are indications of a population concentration, but not definitive. The metropolitan or micropolitan indicator was assigned a weight of 1 because it most clearly identified the most populous communities in the state.

With the addition of the population indicators, an additional seven counties were identified as "at risk," bringing the total of at risk counties to 34 (shown on Appendix A).

Additional analyses of the data may be important to identify sub populations within counties that are considered at risk. Not only do limitations of the data (discussed below) affect the identification of at-risk communities, but current resources also affect the interpretation of the data. For example, a county with multiple services available in the community may have mitigated risk. The definition of at risk used above does not take into account the efforts and programs already underway that may influence the measures. For that reason, population factors are taken into account when determining what counties are at risk.

Not coincidentally, the counties with the least data are also the ones with the lowest maternal and child populations. As noted earlier, the population concentration is an important factor in considering communities that are "at risk." In the next phase of the grant, an important consideration will be the feasibility of recruiting and retaining an adequately-sized clientele, as well as the availability of community resources to address the identified risks.

Data Limitations:

Unavailable data and small numbers of events are a challenge when identifying risks among some populations in the state, particularly those residing in small counties. To address this and provide rates that are more stable, multiple years of data were used for the measures

when necessary. For those counties with so few events that rates could not even be calculated using five years of data, the indicator is not shown.

While most counties have data available on the majority of the indicators, several are missing data in many areas. For instance, some counties reported no domestic violence, child abuse and school drop outs, also resulting in no rates available. It is unknown if there were actually no occurrences of these events, or if inadequate staffing or reporting capacity resulted in no reporting.

Because data from small population states and counties can be both challenging to obtain and difficult to interpret, the analysis and refinement of the data will continue. For instance, during the 2010 Montana Needs Assessment process, young mothers were noted as having a higher prevalence of low birth weight infants than older mothers. A county-level analysis of the relationship between maternal age and birthweight using confidence intervals and other measures of significance is underway, but not completed in time for the ACA Home Visiting Needs Assessment. Also, analysis of some birth data by zip code were not available for submission with the ACA Home Visiting Needs Assessment, but may be useful in identifying additional concentrations of "at risk" populations within the state's metropolitan and micropolitan areas.

QUALITY AND CAPACITY OF EXISTING HOME VISITING PROGRAMS

In anticipation of home visiting expansion related to health care reform, the Family and Community Health Bureau (FCHB) began gathering information regarding home visiting programs in the state in the spring and into the fall of 2010. The FCHB within the Public Health and Safety Division of the Montana Department of Public Health and Human Services, is designated as Montana's Title V agency and is responsible for overseeing many of the maternal and child health programs in Montana. The FCHB staff administers the federal MCH Block

Grant through contracts with county health departments for providing MCH services in their counties.

Each of the 56 county health departments is contractually required to complete the Pre-contract Survey in the spring of each year. A county health department can opt out of receiving MCH Block Grant funding and in turn they do not complete a Pre-contract Survey. The Pre-contract Survey serves as an annual needs assessment and helps the county establish plans for the coming year.

The Pre-contract Survey queries the county health departments on a number of issues, in particular, what types of home visiting services are provided and if they do provide home visiting services, what populations receive home visiting services. The 2010 Pre-contract Survey findings and additional information gathered from other organizations providing home visiting services to the MCH populations are described below.

County Health Departments and Home Visiting Programs:

Home Visiting Program Models Used: In preparation for completing the ACA Home Visiting Needs Assessment, the 2010 Pre-contract Survey was slightly modified to gather additional information from the county health departments. An additional question, *"What model(s) of home visiting for pregnant or postpartum women, infants, or young children does your health department follow? Choose all that apply"* was added if the health department responded yes to the question: *"Does your health department have any home visiting program(s)?"*

Compared to the 2009 results, three more county health departments, or 39 indicated that they intended to provide home visiting services in 2010. Their answers to the additional

question, as to the model or models that they followed, indicated that: 19 didn't follow a model; 15 used the Public Health Home Visiting (PHHV) model; 2 used the Parents as Teachers model; and 5 responded other model. The responses for other model used included: Combination of Best Beginnings and NCAST, Circle of Security, anticipatory guidance within "Bright Futures" an some of Follow Me, packet of information including immunizations, safe sleep, growth and development, poison prevention, and a book called "Your Baby's First Year" by Steven P Shelov, M.D., and an MCCHD model. Multiple responses were allowed. See Figure 1.

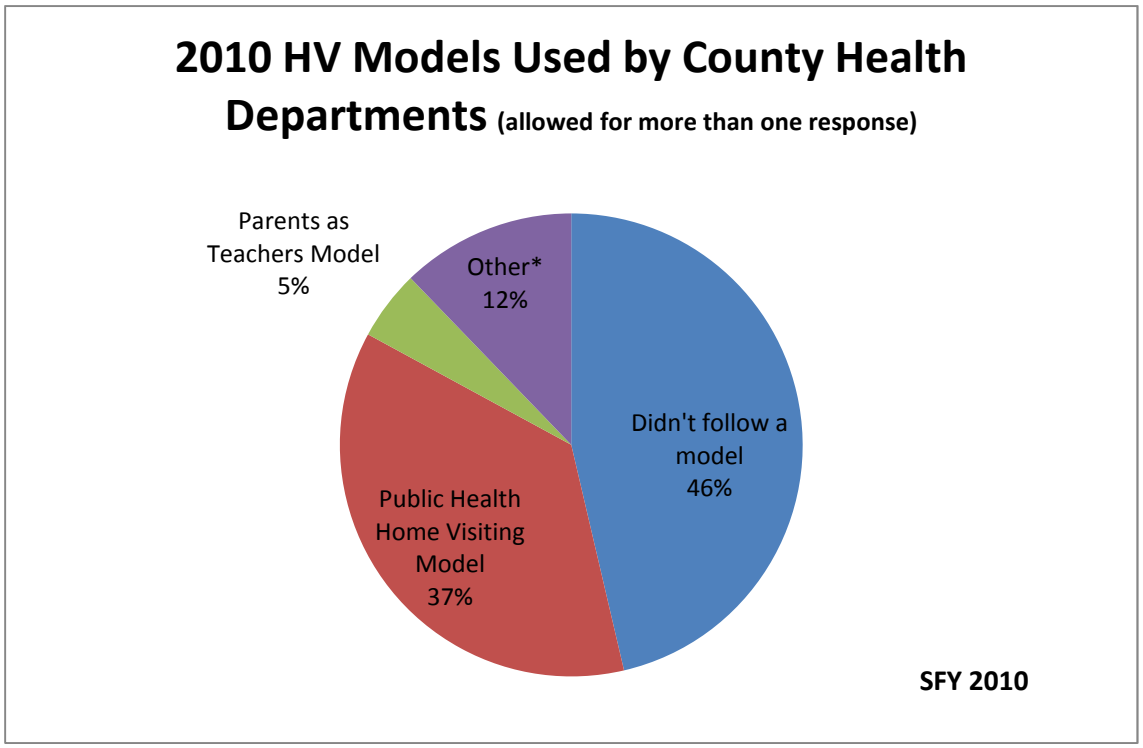

Figure 1

EARLY CHILDHOOD HOME VISITING PROGRAMS

To aid in determining number and types of individuals and families who received or are receiving services under home visiting programs, the FCHB staff, in partnership with representatives from the Early Childhood Services Bureau, the Head Start Collaboration Office,

the Chemical Dependency Bureau (within the Addictive and Mental Disorders Division of the Department of Public Health and Human Services), the designated Single State Agency for Substance Abuse Services, and the Children's Trust Fund, [which is responsible for Montana's Title II of the Child Abuse Prevention and Treatment Act (CAPTA)] held an ACA Home Visiting Teleconference with their respective partners. Also invited to participate in the teleconference were the local Lead Public Health Officials, Tribal Health Service representatives, and advocacy organizations, including the March of Dimes, Montana Healthy Mothers/Healthy Babies and the Montana Council for Maternal Child Health.

The teleconference had three purposes. The participants were:

1. Informed of the health care reform legislation and the state's intent to apply;
2. Invited to participate in the ongoing ACA Home Visiting planning; and,
3. Asked to identify additional entities offering home visiting services and programs for pregnant or postpartum women, infants, or young children.

The participants were asked to send their home visiting contact information to FCHB staff by calling or sending messages to the established ACA HV e-mail account posted on the FCHB website. http://www.dphhs.mt.gov/PHSD/family-health/FCHB-index.shtml

All the organizations, identified on the 2010 Pre-contract Survey or from the June 17, 2010 Teleconference, were contacted. A series of surveys were conducted to compile data regarding home visiting programs in Montana in 2010. The following summarizes the survey findings.

Home Visiting Services by Non-county Health Department Organizations:

In response to the solicitation for information about additional home visiting programs, 80 organizations or agencies were identified in 29 counties. All 80 organizations or agencies

were sent a survey and contacted by the FCHB staff either by telephone and/or e-mail in the summer of 2010. Of the 80 agencies, 31 non-county health department agencies stated they did provide home visiting services, 25 stated they did not provide home visiting services and 23 did not respond to the survey or subsequent follow up contact(s).

The 31 non-county health department home visiting agencies or organizations that provided home visiting services were asked to provide information about the following: their home visiting services' primary focus, the services that were provided, home visitor requirements, outcome measures and whether or not a conceptual model was used. Not all organizations responded to all questions. A summary of the information gathered is presented in this section.

Non-County Health Department Home Visiting Agencies/Organizations Model/s Used:

The non-county health department home visiting agencies or organizations were asked to identify if they used a particular home visiting model to guide their home visiting services, and if so, which model. A list of possible models was provided, along with an option to choose "no particular model" or "other." The organizations responded to the question, with three sites responding that they used two models, and one site reporting they used three models. Ten organizations reported they used the Parents as Teachers model. Five organizations reported they followed no particular model, and three each used the Home Instruction for Parents of Preschool Youngsters (HIPPY) model or the Nurturing Parent Program model. A chart indicating the responses by model is included as Figure 2.

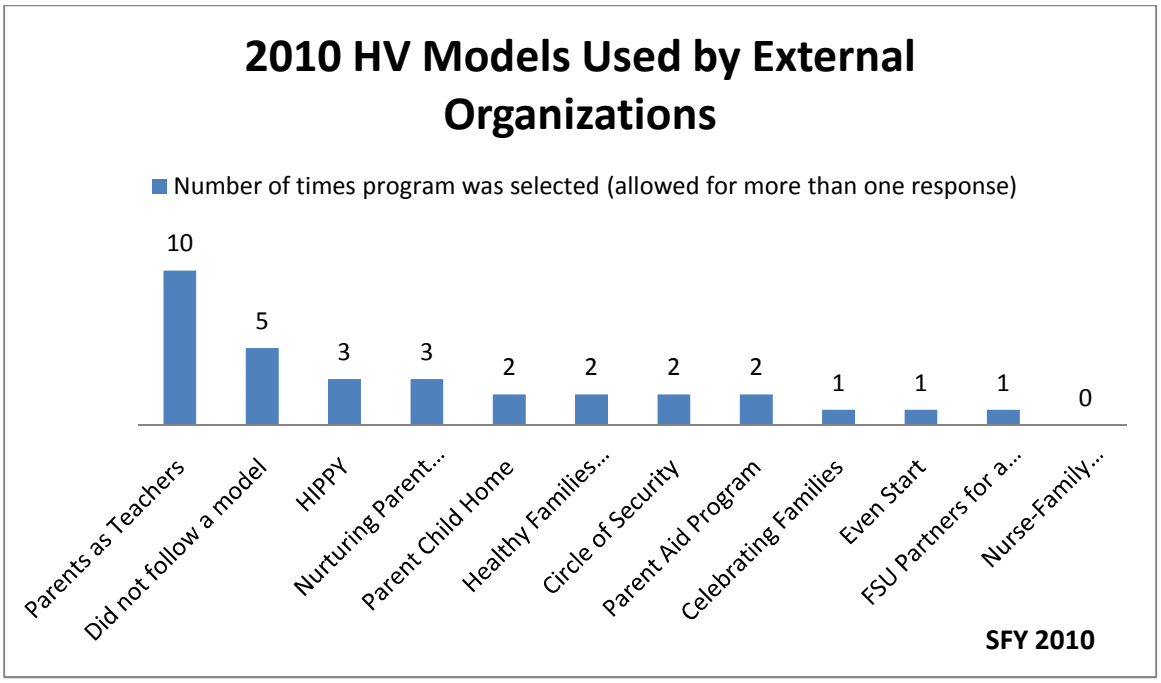

Figure 2

The non-county health department home visiting agencies or organizations were asked to describe their primary focus in the form of an open-ended statement. The statements were examined and grouped into twelve predominant foci, using key word indicators. Several organizations' descriptions of primary focus appeared to identify multiple primary foci. For example, one organization offering pre-school services stated that the program included services addressing health referrals, mental health, literacy and family advocacy. Another listed four foci. Most organizations identified one or two primary foci, and three indicated no particular focus. The foci most likely identified were family education/parenting and support and referral services. A summary of the foci and the number of agencies responding to each is included in Table 4.

2010 Foci for Non-County Health Department Home Visiting Organizations	
Focus	**Number of Organizations Indicating as Primary Focus**
Early childhood education	2
Family Education/Parenting	7
Family Health	1

Support/Referrals	6
Mental Health	2
School Readiness/Literacy	4
Developmental Disability Services	3
Child Abuse/Neglect Prevention	3
Child Development	2
Teen Parent Services	2
Preschool/Child Care	6
Family Preservation/Reunification	1

Table 4

The academic or educational requirements for home visitors was also assessed. Twelve organizations indicated social work as the preferred educational requirement. However, social work appeared to be variably defined, as social workers were described as having a Bachelor's Degree in education, social work, health or a related field; an Associate's Degree in human services; "other college degree and experience working with families," or "comparable experience." The second most identified background requirement was having "early childhood qualifications" variably described as having an undergraduate to graduate degree in early childhood or being an early childhood educator. The third most identified educational requirement was trained paraprofessional, also variably described as being state certified as a family support specialist, having an Associate's Degree in general or social services or being certified in a particular model or program. The survey responses demonstrated that there is great variability in the educational requirements and expectations for home visitors from program to program and community to community. Educational requirements are presented in Figure 3.

2010 Educational Requirements for Home Visitors
(allowed for more than one response)

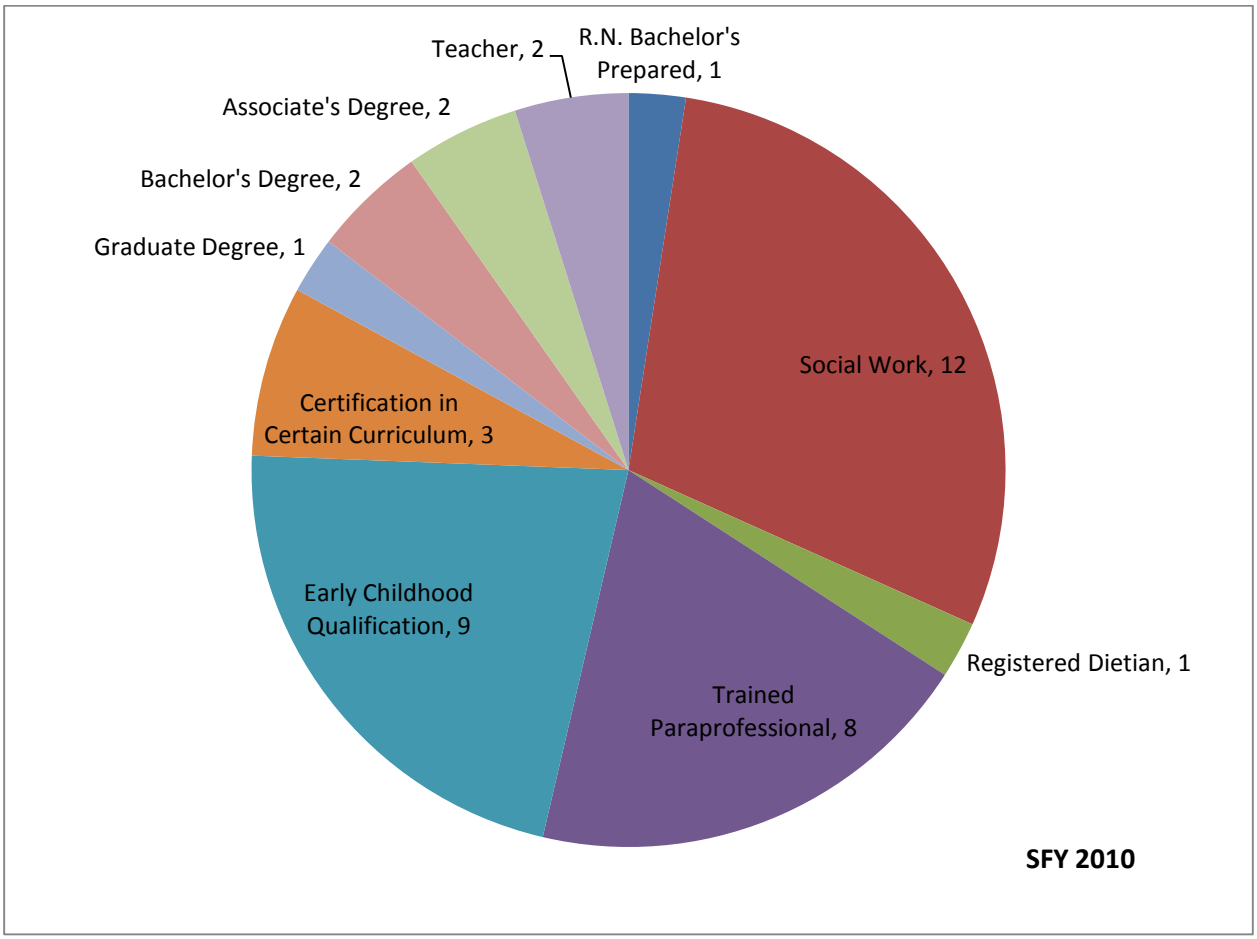

Figure 3

Non-County Health Department Home Visiting Agencies/Organizations: Populations Served:

Organizations were asked to describe the populations served and eligibility requirements for their populations. Most programs reported serving young children aged 1-5. Many programs reported serving a variety of clients, including families, fathers, and grandparents. Numbers of organizations serving various populations are pictured in Figure 4.

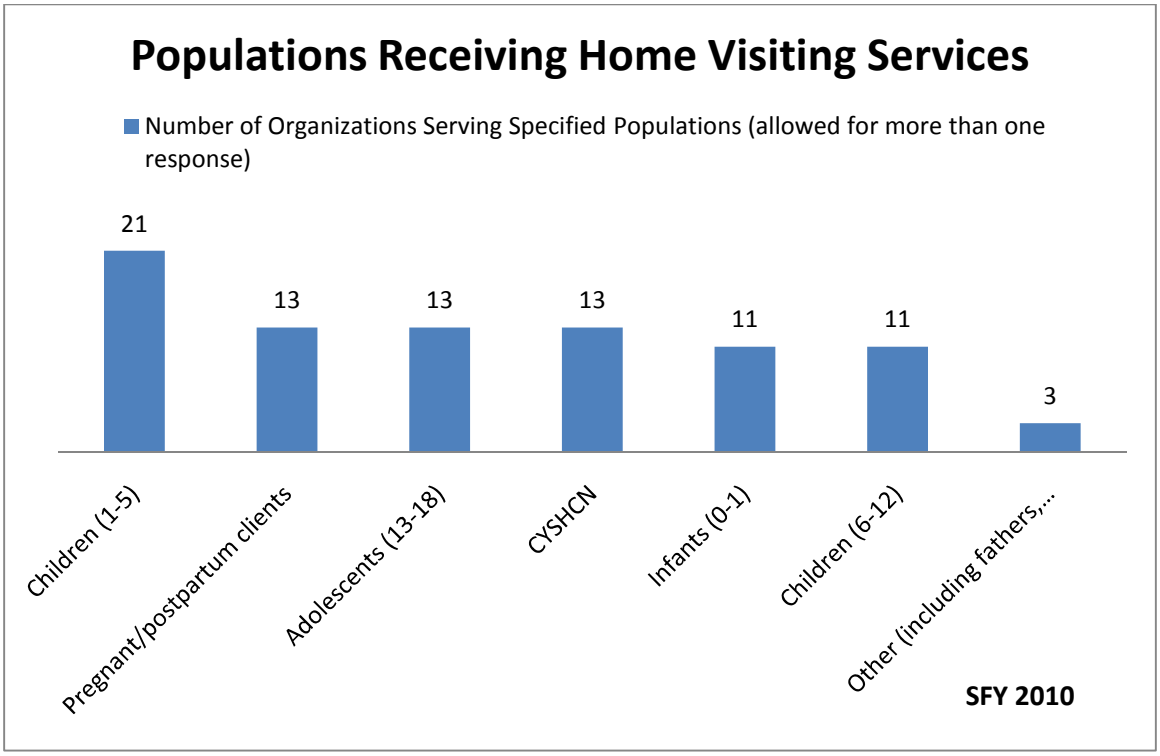

Figure 4

Caseload numbers varied widely, ranging from 0 (indicating no clients in a particular category) to >50 per year. Client eligibility most commonly included income guidelines (poverty level), age of child or parent (teen mothers), or referral from Child and Family Services (Montana's child abuse prevention agency). Risk of abuse and neglect, foster care placement, "geography" and educational achievement were all identified eligibility criteria.

AVAILABILITY AND ADEQUACY OF HOME VISITING SERVICES

Meeting the Needs of Eligible Families: The above-mentioned surveys mentioned in previous sections provided information regarding the availability of home visiting services for the MCH population in the state. In 2008, 10,536 of the 12,592 (84%) births in the state occurred in counties with one or more home visiting programs. However, eligibility for programs varies from county to county, and the geographic coverage also varies. While PHHV

program contractors are charged with providing services county wide to high risk pregnant women and infants and infants with special health care needs, other home visiting programs may serve only one city, town or a portion of a county or may be targeted to a very specific population.

"Adequacy" of home visiting services implies not only access or availability, but also quality of services. Not all home visiting services currently in Montana have evaluation plans or even criteria established with which to evaluate quality. Head Start programs have federally established criteria with which to monitor program success, including health and other measures. Ongoing evaluation of the current PHHV home visiting program is underway.

SUBSTANCE ABUSE COUNSELING AND TREATMENT SERVICES AND CAPACITY

Populations at risk for substance abuse of marijuana, prescription drug or illicit drugs, and binge alcohol use have a more difficult time accessing services. In 2010, all or parts of 55 of 56 of Montana's counties were designated as Primary Care Health Professional Shortage Areas (HPSA) and all 56 counties were designated as Mental Health Professional Shortage Areas. The HPSA designations document that every county in the state has a shortage of mental health professionals, and all but one has a shortage of primary care providers available to at least a portion of the county. The end result is that accessing mental health services for substance abuse counseling is challenging across the state. For additional information on Montana's HPSA designation areas go to the Primary Care Office webpage at:

http://www.dphhs.mt.gov/PHSD/Primary-Care/primary-care-index.shtml

Tobacco cessation services are widely available throughout Montana through the Montana Tobacco Use Prevention Program, with programs in 43counties. The PHHV

Contractors are required to refer their clients to the tobacco cessation program. For additional information go to: http://tobaccofree.mt.gov/index.shtml

Limitations of the ACA Home Visiting Needs Assessment: As noted earlier, the measures are general and county-level data may not sufficiently identify all concentrations of at risk population. Variability of rates from county to county and missing data leaves room for some flexibility in determining which counties have "at risk" populations. Coverage and cost also need to be carefully considered. Community readiness, as well as community capacity must be a consideration in the development of any home visiting services. This ACA Hoome Visiting Needs Assessment does not factor in resource availability and other elements which would influence the success of home visiting services in a community.

Conclusion

Montana has a long history of providing home visiting services for the MCH population. Recent developments in home visiting programs in the state include adoption and application of program models and evaluation plans and establishment of standardized data collections for some programs. State level efforts to examine the purpose, structure and intent of programs and to establish and implement standardized evaluation have shaped and continue to improve the home visiting program service delivery.

Effective programs must clearly state and pursue program goals, identify target populations, recruit and train home visitors, base programming on theoretical models, and carefully and consistently evaluate programs, revising and rebuilding as needed. Because of the small size of the maternal and child health population in the state and limited resources, Montana's ACA Home Visiting Program will most likely focus on a single model.

The FCHB plans to meet with the stakeholders previously identified in this document to to examine needs, resources, and related data to determine the most effective model to address the needs of at risk populations and communities, and to establish the guidelines for a state issued Request for Proposal. The Request for Proposal will be open to organizations that provide home visiting services, such as county health departments and the non-county health department organizations which are equipped to effectively serve the at population by implementing the approved home visiting model, establishing measurable goals and evaluating the program.

The letters of concurrence from the Head Start Collaboration Office, the Chemical Dependency Bureau (within the Addictive and Mental Disorders Division of the Department of Public Health and Human Services), the designated Single State Agency for Substance Abuse Services, and the Children's Trust Fund, [which is responsible for Montana's Title II of the Child Abuse Prevention and Treatment Act (CAPTA)] document the willingness for the state of Montana to improve the health and well being of the maternal and child health population. See Appendix 2: Letters of Concurrence.

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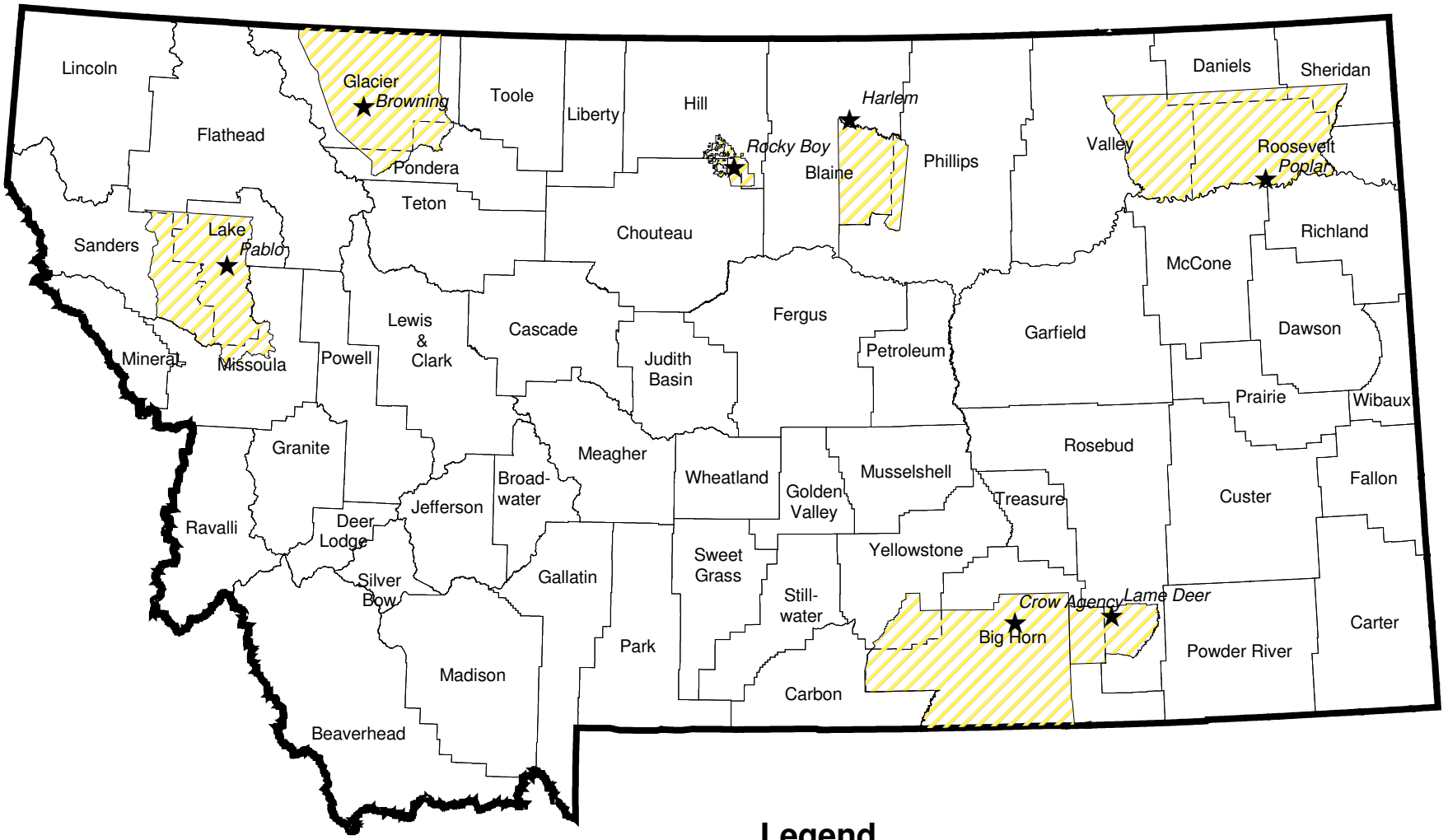
Appendix 1

Montana Counties and American Indian Reservations



Legend

★ IHS Facilities

American Indian Reservations

HRSA Award #6X02mc 19410-01-01
Montana ACA Home Visiting Needs Assessment

Prepared by John Schroeck, MT DPHHS Primary Care Office

Appendix 2

DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES

Brian Schweitzer
GOVERNOR

Anna Whiting Sorrell
DIRECTOR

STATE OF MONTANA

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September 15, 2010

Audrey M. Yowell, PhD, MSSS
Health Resources and Services Administration
Maternal and Child Health Bureau
5600 Fishers Lane 18A-39
Rockville, MD 20857

Dr. Yowell:

The purpose of this letter is to document support of, and concurrence with, the Family and Community Health Bureau's plan to apply for the ACA Maternal, Infant and Early Childhood Home Visiting Program for Montana. The plan supports the Bureau's efforts to provide home visiting services to maternal child health populations as authorized in Montana's Initiative for the Abatement of Mortality in Infants, which was signed into state law in 1989, and provides for community based programs to serve high risk pregnant women and infants with a goal of improving pregnancy outcomes and decreasing infant mortality.

The ACA program will also support the Bureau's ability to comply with Title V of the Social Security Act, which charges state Title V agencies with developing and expanding …"maternal and infant health home visiting programs in which case management services, health education services, and related social support services are provided in the home to pregnant women or families with an infant up to the age one by an appropriate health professional or by qualified nonprofessional acting under the supervision of a health care professional." (Title V SSA Section 501 (a) (3 http://www.ssa.gov/OP_Home/ssact/title05/0501.htm).

The Bureau will assure that phase three of the ACA application process is submitted per the Program's Funding Opportunity Announcements.

Signed,

Joan Bowsher

Joan Bowsher
Acting Bureau Chief, Family and Community Health Bureau

Appendix 2

September 15, 2010

Audrey M. Yowell, PhD, MSSS
Health Resources and Services Administration
Maternal and Child Health Bureau
5600 Fishers Lane 18A-39
Rockville MD 20857

Dr. Yowell:

The purpose of this letter is to document support of, and concurrence with, the Family and Community Health Bureau's submission of the statewide needs assessment for the receipt of the Affordable Care Act, Maternal, Infant and Early Childhood Home Visiting Program for Montana. The Board of Montana Children's Trust Fund will continue to work with the Family and Community Health Bureau on the next steps for implementing an evidence based home visiting program in Montana.

The Montana Children's Trust Fund mission is "Strengthening & Supporting Montana Families, Preventing Maltreatment of Montana Children." In accordance to federal legislation, the Montana Children's Trust Fund is collaborating with Maternal, Infant and Early Childhood Home Visiting programs. We welcome the opportunity to support Montana's children with the home visiting programs within the state.

The Montana Children's Trust Fund Board supports the development and implementation of an evidenced based home visiting program(s) for pregnant and parenting families, which is the intent of the ACA grant as one of several ways Montana may help protect children and strengthen families.

Sincerely,

Betty Hidalgo, R.N.

Betty Hidalgo, RN
Montana Trust Fund Board, Chair

Appendix 2

DEPARTMENT OF
PUBLIC HEALTH AND HUMAN SERVICES

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September 15, 2010

Audrey M. Yowell, PhD, MSSS
Health Resources and Services Administration
Maternal and Child Health Bureau
5600 Fishers Lane 18A-39
Rockville MD 20857

Dr. Yowell:

The purpose of this letter is to document support of, and concurrence with, the Family and Community Health Bureau's submission of the statewide needs assessment for the receipt of the ACA Maternal, Infant and Early Childhood Home Visiting Program for Montana. As the Chief of the Early Childhood Services Bureau within the Human & Community Services Division of the Department of Public Health and Human Services, I am the designated state child care administrator. Our Division's mission is dedicated to helping children and families succeed by increasing the affordability, accessibility and quality of early care and education.

We recognize that supporting families and children in a child's early years is critical to the success and well being of children as they grow. With the science of brain development, we know that so much can be done in the early years that will lead to lifelong success. We also know the reverse is true, that if children receive adverse experience in their early years, they will be impacted throughout their lives. We support the development and implementation of an evidenced based home visiting program(s) for pregnant and parenting families that is the intent of the ACA grant as one of several ways Montana may help protect children and strengthen families.

Sincerely,

Jamie Palagi

Jamie Palagi, Chief
Early Childhood Services Bureau

Appendix 2

DEPARTMENT OF
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September 8, 2010

Audrey M. Yowell, PhD, MSSS
Health Resources and Services Administration
Maternal and Child Health Bureau
5600 Fishers Lane 18A-39
Rockville MD 20857

Dr. Yowell:

The purpose of this letter is to document support of, and concurrence with, the Family and Community Health Bureau's submission of the statewide needs assessment for the receipt of the ACA Maternal, Infant and Early Childhood Home Visiting Program for Montana. As the Chief of the Chemical Dependency Bureau within the Addictive & Mental Disorders Division of the Department of Public Health and Human Services, I am the designated Single State Agency Substance Abuse Services Director. Our Division's mission is to "implement and improve an appropriate statewide system of prevention, treatment, care and rehabilitation for Montana's with mental disorders or additions to drugs or alcohol."

We recognize the impact that substance use by family members may have on developing fetuses, infants and young children, and encourage the development of evidence based practices that help prevent and treat addictions. We also recognize home visiting as one of many mechanisms that may help families suffering from addiction, by providing support and guidance in familiar surroundings. We support the development and implementation of an evidenced based home visiting program(s) for pregnant and parenting families that is the intent of the ACA grant as one of several ways Montana may help protect children and strengthen families.

Joan Cassidy

Joan Cassidy, Chief
Chemical Dependency Bureau

Appendix 2

DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES

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September 15, 2010

Audrey M. Yowell, PhD, MSSS
Health Resources and Services Administration
Maternal and Child Health Bureau
5600 Fishers Lane 18A-39
Rockville MD 20857

Dr. Yowell:

The purpose of this letter is to document support of, and concurrence with, the Family and Community Health Bureau's submission of the statewide needs assessment for the receipt of the Affordable Care Act, Maternal, Infant and Early Childhood Home Visiting Program for Montana. As the Montana Head Start Collaboration Director, I am committed to facilitating necessary collaboration between state agencies and among Head Start and Early Head Start programs. I work frequently on various issues and projects with the Family and Community Health Bureau and will continue to work with them on the next steps for implementing an evidence-based home visiting program in Montana.

The mission of the Collaboration Office is to ensure that low income families and children have access to the services that they need and that young children in Montana are healthy and ready for success in school and life. The home visiting grant is a wonderful and welcome opportunity to meet some families where they need the most help. During my many years as the home based supervisor in a Head Start program, I know personally that home visiting can be vital for some families to thrive.

The Montana Head Start programs and the Head Start Collaboration Office support the development and implementation of an evidenced based home visiting program(s) for pregnant and parenting families that is the intent of the ACA grant as one of several ways Montana may help protect children and strengthen families.

Thank you for this opportunity.

Sincerely,

Mary Jane Standaert, Director